DRUG PRIOR AUTHORIZATION REQUEST FORM (MAP-82001, rev. 1/30/2003)

FAX to 866-863-8803 (toll free)

For **URGENT** Requests Only, FAX to **800-877-2219** (toll free)

For **NURSING FACILITY** Requests Only, FAX to **(866) 863-9171** (toll free)

MAIL to PA Unit, PO Box 2103, Frankfort, KY 40602. Put return address below:

Submitted by: [ ] Prescriber [ ] Pharmacy

Approval does not ensure eligibility. Please verify Medicaid eligibility before completing this form.

REQUEST TYPE (please check): ☐ **PRIOR AUTHORIZATION** ☐ **MEDICARE PART B OVERRIDE** ☐ **QUANTITY LIMIT OVERRIDE**

☐ **OTHER** _____

RECIPIENT NAME	MAID #	DATE OF BIRTH

	PRESCRIBER Information	PHARMACY Information
Name		
Phone #		
Fax #		
License #		

DRUG NAME (Use extra forms for more than 4 drugs.)	Dosage Form	Strength	Quantity	Directions for use	Start Date for this PA	National Drug Code (if known)
#1						
#2						
#3						
#4						

HAS THE REQUESTED DRUG BEEN PRIOR AUTHORIZED PREVIOUSLY? [ ] YES [ ] NO [ ] UNKNOWN

PERTINENT DIAGNOSES _____

CURRENT MEDICATIONS _____

_____

MEDICAL JUSTIFICATION (including drugs already tried) _____

_____

_____

MEDICARE PART B REQUEST REASON (PLEASE CHECK ONE): (A copy of the Medicare EOB denying coverage must accompany each request)

☐ RECIPIENT IS NOT MEDICARE PART B ELIGIBLE

☐ RECIPIENT IS TAKING THE MEDICATION FOR AN INDICATION THAT IS NOT COVERED BY MEDICARE

☐ OTHER (PLEASE EXPLAIN ABOVE)

☐ DRUG DOES NOT MEET MEDICARE COVERAGE CRITERIA

	LEAVE THIS SECTION BLANK
DRUG #1	
DRUG #2	
DRUG #3	
DRUG #4	